PRINTED: 04/15/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155660		(X2) MULTIPLE CONSTRUCTION A. BUILDING		INSTRUCTION	COMPLETED 03/25/2011		
		100000	B. WIN			03/25/2	.011
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
PULASK	I HEALTH CARE CE	ENTER		1	3TH ST IAC, IN46996		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC1)		DATE
F0000	This visit was for State Licensure S	r a Recertification and Survey.	F00	00			
	Survey Dates: M 25, 2011	March 21, 22, 23, 24, and					
	Facility Number:	: 000553					
	Provider Number: 155660						
	AIM Number:	100267430					
	Survey Team:						
	Kelly Sizemore RN, TC						
	Marcia Mital, RN	N					
	Sheila Sizemore,	RN					
	(March 21, 23, 2	4, and 25, 2011)					
	Census Bed Type	2 .					
	SNF/NF: 47						
	SNF: 7						
	Total: 54						
	Census Payor Ty	pe:					
	Medicare: 5						
	Medicaid: 28						
	Other: 21						
	Total: 54						
	Sample: 14						
	Supplemental: 4						
		es also reflect state					
	findings cited in 16.2.	accordance with 410 IAC					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PVJH11

Facility ID:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		624 E 1	ADDRESS, CITY, STATE, ZIP COD 13TH ST IAC, IN46996	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Quality review c 2011 by Bev Fau	completed on March 29, alkner, RN				

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ONSTRUCTION	(X3) DATE S	ETED
		155660	B. WING	<u> </u>		03/25/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PULASK	I HEALTH CARE CE	ENTER	624 E 13TH ST WINAMAC, IN46996				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		E02	TAG	F-225 Any and all alleged		DATE
F0225	Based on record review and				violations involving mistreatme	ent,	04/24/2011
SS=D		e facility failed to			neglect, or abuse of residents including injuries of unknown		
	ensure an all	legation of			origin and misappropriation of		
	misappropria	ation of a resident's			resident property will be report immediately to the Administrat		
	property was	s reported to the			and other officials in accordan	ce	
	Indiana State	e Department of			with State Law through established procedures (include	ding	
	Health in a t	imely manner, for			to the State Surevey and		
	1 of 2 allegations of				Certification Agency). Notificato the Indiana State Departme		
	misappropriation of resident's				of Health , Adult Protective		
					Services and the Area		
	property rev	iewed. (Resident			Ombudsman will be made with a 24 hour time period of the	n in	
	#10)				reported incident All residen	ts	
	Findings inc	lude:			in the facility are identified as potentially affected by the deficient practice. timely reporting (with in 24 hours) to ISDH, APS and area	the	
	1. Review o	of an investigation,			Ombudsman will occur by the Administrator or designee upo		
	dated 12/23/	10, indicated			an allegation of a violation		
		O's granddaughter			involving mistreatment, negled or abuse of a resident includin		
		resident's wedding			injuries of unknown origin and	٠ .	
	_	issing on 12/20/10.			misappropriation of resident property During the survey		
		•			process, An in-service was giv	/en	
	U	ation indicated on			to all staff concerning the		
	12/23/10 the	Administrator			immdeiate notification of the Administrator or designee of a	ny l	
	indicated she	e had "spoke to			allegations of abuse or		
	CNA (name) today & she made				misappropriation of resident property. See attached		
	the statemen	t that on			in-service. The Administrator		
	12-21-2010	(Resident #10's			reviewed with the Director of Nursing, the Assistant Director	r of	

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY COMPLETED	
ANDIEM	or correction	155660	A. BUII B. WIN	LDING		03/25/2011	
NAME OF I	DROLUDER OR CURRULER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	3TH ST		
	I HEALTH CARE CE				IAC, IN46996		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPI	X5) LETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DA	
	name) sat on	the edge of the			Nursing and office personnel, responsibilities of the person	the	
	bed and stated my ring is			named as designee by the	1		
	missing a gir	rl took it off my			The responsibilities are to incl	ıde	
	finger at 3:0	0 in the morning"			the reporting requirements to ISDH, APS and Area		
	 During an in	terview on 3/22/11			Ombudsman with in 24 hours reported alleged incident Weekly the Administrator will	OT	
	at 3:30 p.m.,	the Administrator			keep a log for reported allegations of resident abuse of	ur.	
	indicated the	e CNA had reported			misappropriation of resident	"	
	what Reside	nt #10 had told her			property. To ensure timely reporting the Administrive		
	to her nurse.	She indicated it			Assistant will monitor the log kept by the Administrator for timeliness		
	was the even	ning shift on			of reporting to the ISDH, APS,		
	12/21/10. Si	he indicated the			and Area Ombudsman.(wih in hours of alleged abuse or	24	
	nurse had pu	at the information			missappropriation of resident property) The Administrator w	ıill l	
	on the 24 ho	our report sheet and			report, to the Risk Manageme	nt	
	she found ou	it about what the			team weekly and to the Quality Assurnace team quarterly, the		
	resident had	said when she			results of the allegation log an reporting time frames	d	
	came into w	ork in the morning			Completion date 4-24-2011		
	on 12/22/10.	She indicated she					
	was still con	sidering the					
	wedding ring	g a missing item					
	and was alre	ady investigating.					
	She indicate	d it was hearsay					
	until she talk	xed to the CNA.					
	She indicated	d she had talked to					
	the CNA on	12/23/10. She					
					!		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		STREET A 624 E 1	ADDRESS, CITY, STATE, ZIP COE 13TH ST IAC, IN46996	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	indicated she missing wed	e reported the ding ring on ree days after it		CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155660	B. WIN			03/25/2011	
NAME OF F	PROVIDER OR SUPPLIER			624 E	ADDRESS, CITY, STATE, ZIP CODE		
PULASK	I HEALTH CARE CE	ENTER		WINAN	MAC, IN46996		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
F0226	Based on rec	cord review and	F02	26	F-226 The policy relating to reporting allegations of	04/24/2011	
SS=D	interview, th	e facility failed to			missappropriation of residents		
	follow their	policy related to			property to the Indiana State Department of Health was		
	reporting all	egations of			reviewed and updated All the residents in the facility are		
	misappropria	ation of residents			identified as potentially affecte		
	property to t	he Indiana State			by the deficient practice The ploicy relating to reporting		
	Department	of Health in a			allegations of misappropriation residents property to the India		
	timely mann	er for 1 of 2			State Department of Health ,		
	allegations o	of misappropriation			Adult Protective Services and Area Ombudsman was review	ed	
	of residents j	property reviewed.			and updated. The policy was presented to all department		
	Findings inc	lude:			managers and front office personnel at the weekly Risk Management meeting. The poto include specific time frames		
	1. Review o	of an investigation			allowed for the reporting of an incident of alleged abuse or		
		10, indicated			misapropriation of resident property. The incident must be	<u>, </u>	
	Resident #10)'s granddaughter			reported no later than 24 hour	s	
	reported the	resident's wedding			post incident to the ISDH, APS and area Ombudsman. A follow		
	band was mi	ssing on 12/20/10.			up report must be reported to ISDH, APS, and area	the	
	The investig	ation indicated on			Ombudsman not later than 5 c		
	12/23/10 the	Administrator			following the initial report date All policies and procdedures w		
	indicated she	e had "spoke to			be annually reviewed and updated as needed, or as Fed	eral	
	CNA (name)	today & she made			and State regulations changes	s	
	the statemen	t that on			occur. The policy on reporting ISDH, APS and area) to	
	12-21-2010	(Resident #10's			Ombudsman will be followed f all allegations of resident abus		
	name) sat on	the edge of the			or misappropriation of residen		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2011
	PROVIDER OR SUPPLIER		STREET. 624 E ^	ADDRESS, CITY, STATE, ZIP CODE 13TH ST MAC, IN46996	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	missing a gir finger at 3:0 During an in at 3:30 p.m., indicated the what Reside to her nurse, was the ever 12/21/10. So nurse had pure on the 24 he she found our resident had came into work on 12/22/10, was still compared was alrest she indicate until she talk. She indicate the CNA on	he indicated the at the information our report sheet and at about what the said when she ork in the morning. She indicated she		property. Weekly, the Administrator will report to the Risk Management team the results of the log concerning timely reporting to ISDH, APS and area Ombudsman. The initial reporting to be done wit 24 hours of the incident. The follow up report should be ser within 5 days of the initial reportent. Weekly results of the log will be reported to the Quarterly Quality Assurance Team at the Quarterly Quality Assurance meeting. Respons person: The Administrator- Completion date 4-24-2011	i, n in nt ort

Facility ID:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		624 E 1	ADDRESS, CITY, STATE, ZIP CODE 3TH ST IAC, IN46996	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	missing wed 12/23/10.	lding ring on				
	titled "ABU POLICY", in reports or su abuse shall b	SE PROHIBITION Indicated "All Ispected or known the reported to In State Department				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155660		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE : COMPL	ETED	
		155660	B. WIN			03/25/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CARE CE				IAC, IN46996		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)	E02	TAG	`		DATE
F0253		ation and interview, the	F02:	53	F-253 Front Lobby - Buffet Cabineta. Maintenance sande	ed.	04/24/2011
SS=C	_	ensure housekeeping and			and refinished the surface of the		
		vices were provided to			buffet cabinetb. All wood		
	maintain a sanita	ry and comfortable			surfaced furniture in the buildir	-	
	interior related to	missing veneer, cracked			will by checked and repaired for		
	light covers with	bugs in them, dirty,			proper finish, in order to ensur	e a	
	leaking ice mach	ine, dirty cabinets, trash			sanitary , orderly, and comfortable interiorc. Quality		
	can without a lid.	, dirty, marred, and			assurance checks will be done	;	
		ouged walls, chipped			weekly for one month and ther		
	paint, torn and dirty chair, and cracked				monthly on-going by the		
		4 of 5 halls, 1 of 2 dining			maintenance personnel. The		
	_	inges (main dining room,			maintenance director will overs process to ensure sanitary,	see	
		uth, West, East, and			orderly, and a comfortable inte	rior	
	•				is maintained. the quality chec		
	,	his had the potential to			will be presented at the Quarte		
		esidents who reside in the			Quality Assurance meeting.Ma	ain	
	facility.				Dining Room - Light coversa.		
					Two light covers wwere ordere	ed	
	Findings include	:			and replaced b. All the light covers in the building were		
					checked for cracks in the cove	rs	
	During the enviro	onmental tour on 3/24/11			and replaced if neededc.		
	at 9:55 a.m. throu	ugh 11:05 a.m., with the			Maintenance will be doing qua		
	Environmental D	Director and Maintenance			checks weekly for 1 month and		
	Director, the follo	owing was observed:			then monthly on-going to ensu a sanitary, orderly, and	re	
	Front Lobby:				comfortable interior. d. The Maintenance Director will over process and the quality checks		
	A 1. CC. / 1 * / 1	La La Lanca de la Calanda			will be presented at the quarte		
		had a large water spot			Quality Assurance meeting.La	dy	
	_	eer off of the top of the			Bugs in Light Covera. The ligh		
	buffet.				covers were cleaned and free		
	Main Dining Roo	oom: building were che bugs and sanitar		lady bugsb. All light covers in building were checked for lady bugs and sanitary condition ar cleaned if needed.c.	,		
	Two of five light	covers were cracked and			Housekeeping will be cleaning		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DING		COMPLETED	
		155660	A. BUILDING		03/25/2011	
			B. WING	A DDD EGG CHTW GTATE THE CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
			I	13TH ST		
PULASK	I HEALTH CARE C	ENTER	WINAN	MAC, IN46996		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	one of the light	cover had six lady bugs in		the light covers on a weekly b		
	it. During an in	terview at the time of the		to maintain a sanitary, orderly and comfortable interior.d.	',	
	observation, the	Environmental Director		Quality checks will be done		
	· ·	like lady bugs" and "I see		weekly by the Housekeeping		
	the cracks."	Time rady sugs und 1 see		supervisor and presented to t	he	
	the clacks.			quality assurance team at the		
				quarterly meeting.lce Macihne	l l	
	The ice machine	e had water dripping from		Water dripping a. The		
	the ice dispense	r and there was hard water		Serviceman was called and the	ne	
	buildup on the s	creen and drip pan.		company advised us that som	ne	
	1	1 1		dripping occurs as the ice me	lts	
	The bettem eabi	inat halow the gink was		and that this is a normal funct		
	The bottom cabinet below the sink was			of this machine.b. No other id		
	dirty and had white crumbs.			machines of this nature are in	ı the	
				building. c. The inside of the		
	A trash can, with	h garbage in it, did not		machine is scheduled for		
	have a lid.			cleaning every 3 months per		
		view at the time of the		manufacturer		
	1			recommendations.d.		
		Environmental Director		Maintenance will be doing a visual check of the ice machin	ne to	
	indicated it shou	ıld have a lid on it.		ensure the dripping does not		
				worse in-between cleanings.		
	North Hall:			preform quality checks month		
				ensure a sanitary, orderly, an		
	Rooms N2 N2	N7 and N8, the entry way		comfortable interior. These		
	doors were marr			checks will be reported to the		
	doors were man	eu anu scurieu.		Quality Assurance team at the	eir	
				Quarterly meeting for one		
	Room N1, the w	all behind the rocker had		year. Ice Machine - Hard wate	l l	
	ten gouges.			buuild up on the screen and	· ·	
				pana. The drip pan and scree		
	West Hall:			were cleaned and the lime bu	iliu	
				up was removed.b. A quality check will be done on a week	lv	
	D	-1-4 -1-11		basis by Environmental Direc		
	_	paint chipping off inside		for any other lime build up in		
	both window fra	ames.		building. The lime build up w		
				removed and the equipment		
	Rooms W4 and	W6 entry way doors were		maintained.c. Housekeeping	will	
		, <u>, , , , , , , , , , , , , , , , , , </u>				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	COMPLETED		ETED
		155660	B. WIN			03/25/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	R			3TH ST		
חווו אפול	I HEALTH CARE C	ENTED			IAC, IN46996		
		LIVILIX					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	,			TAG	DEFICIENCY)		DATE
	dirty, marred, an	d scuffed.			be cleaning drip pan and scree		
					on a daily basis with the produ	ıct	
	Main Lounge:				specific for the ice machine.d.		
	Trium Zounge.				Quality checks will be done weekly for one month and ther		
	A amaama aalam ya	and about had the might			monthly ongoing and reported		
		nyl chair, had the right			to the Quality Assurance Team		
	corner torn off a	nd was dirty.			their quarterly meeting.Cabine		
					under sinka. The area was		
	The veneer was	off the entire bottom of			cleaned by the housekeeping		
	the fireplace alor	ng the edge.			staffb. The underneath of all si	ink	
					cabinets in the building were		
South Hall:				checked for sanitary conditions			
South Hall.				the Environmental Director and	d		
	TT1 , 1				cleaned if needed. c. The		
	1	oors to the clean and dirty			Housekeeping staff will be cleaning all cabinets under sin	ke	
	1 -	re dirty, marred, and			on a daily basis to ensure a	7.5	
	scuffed.				sanitary, orderly, and comforta	ıble	
					interiord. Quality checks will b		
	Room S1 entry v	way door had two gouges.			done weekly for 1 month and t		
		5 8			monthly ongoing by the		
	Poom SIR had t	Four gouges on the wall			Environment Director and		
					reported to the Quality Assura	nce	
	behind the reclin	ier.			Team at their quarterly		
					meeting.Trash Cansa. The tra	ash	
	Rooms S4 and S	6 entry way doors were			can lids for 3 trash cans were		
	scuffed and mari	red.			ordered and replaced. b. All tr cans requiring lids were check		
					in the building by the	.eu	
	Room S6 right	outside the door in the			Environmental Service Director	r l	
		ing tile was cracked.			and ordered if needed. c. Qua		
	manway, the cen	ing the was clacked.			checks will be done weekly by		
					Environmental Service directo		
	East Hall:				for sanitary checks of the trash		
					cansd. The quality checks will		
	Room E2 the ent	try way door was marred.			be presented to the Quality		
		· ·			Assurance Team and their		
	Room E4 the entry way door was dirty,				quarterly meeting. Entry Way	,,	
					Doors (N2, N3, N7, N8, W4, W		
	marred, and scuf	ICU.			S1, S4, S6, Clean and dirty uti	ııty	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/25/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 624 E 13TH ST WINAMAC, IN46996				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE		
	3.1-19(f)(5)			rooms South Hall, E2, E4,)a. Entry way doors were cleaned and the gouges were filled wood putty and sanded and refinished. Door protector share bing ordered from Direct Supply to cover the bottom of the doors to prevent this from happening again.b. All the din the facility were inspected deterioration and cleanlines. They were then cleaned and resurfaced if needed.c. Maintenance Director will che the condition of all the doors the building weekly for 1 more then monthly on-going to ensure a sanitary, orderly, and comfortable interior. d. Maintenance Director will over process and report findings to Quality Assurance Team at the quarterly meetings. Condition walls and window frame (N1, S1B,)a. Paint was scraped on needed and dry wall mud was applied to the walls and and and window frame was repainted. Chair rails and wordshall rails were ordered for the damaged areas from Direct Supply.b. All the walls in the building were inspected for damage and if found in poor shape will be repaired and maintained and protected if needed.c. Maintenance Direct will do a quality check of the and windows weekly for 1 more then monthly on-going to entry then monthly on-going to entry the monthly on-going	ed bith sheets f coors for eck in coors		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		155660	A. BUILDING		03/25/2011	
		10000	B. WING		00/20/2011	
NAME OF I	PROVIDER OR SUPPLIER	8	ı	ET ADDRESS, CITY, STATE, ZIP CODE		
				E 13TH ST		
PULASKI HEALTH CARE CENTER		ENTER	WIN	AMAC, IN46996		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	a sanitary, orderly, and comfortable interior.d. The quality checks will be presented to the Quality Assurance team at their qual meeting. Cracked Ceiling Tile outside room S6a. The tile we taken down and replaced. b. check will be done on the conditioin of all ceiling tile in the building and replaced if needed.c. The Maintenance director will preform quality checks of ceiling tile weekly the month then monthly on-goingd. The results of the quality checks will be present to the Quality Assurance Teatheir Quarterly meeting. Maint Lounge - Vinyl chiara. The cowas cleaned by housekeepin staff and then removed from building for repair.b. A check be done on the condition and cleanliness of all resident chand furniture in the building weekly for 1 month then moron-going to ensure a sanitary orderly, and comfortable intee the Chairs will be kept clean in good condition. c. The Housekeeping Director will preform the quality checks all report the results to the Qual	terly vas A for 1 ted m at hair ng the k will d airs hthly rior. and	
				Assurance Team at their qua meeting.Main Lounge - Fire Placea. The fireplace venee sanded and refininshed by maintenanceb. All the wood furniture in the building was inspected and refinished if		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP - 03/25/	LETED
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CO	DDE	
PULASK	I HEALTH CARE CI	ENTER		13TH ST 1AC, IN46996		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	 	ECTION	(X5)
PREFIX TAG		DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATI		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	needed by maintenance Quality checks of the co the wood furniture will be preformed by the Enviro Director weekly for 1 me monthly on-going.d. Que checks will be reported maintenance for require and then reported to the Assurance Team at the meetings.	e.c. condition of ce conmental conth then cuality to ced repairs e Quality	DATE

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED 03/35/2011
		155660	B. WIN			03/23/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
PULASK	I HEALTH CARE CE	ENTER			13TH ST //AC, IN46996	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0323		review and interview, the	F03	23	F 323 - Free of Accident Hazards/Supervision/Device-	04/24/2011
SS=G	_	ensure a resident received			Prior to the survey all staff sign	ned
		sion and assistance to			acknowledgement of termination	
	prevent accidents	s related to 1 (#42)			if found to have left a resident	
	_	ft unsupervised in the			with fall risk and poor safety	
	bathroom twice v	which resulted in a			awareness unattended. This valded to new employee	was
	fracture and a lac	ceration and failed to			orientation During the survey	a
	ensure intervention	ons were in place for 1			Star Program was put into place	
	` /	nich resulted in a fall for			Nursing Form #1. This was	
	2 of 7 residents 1	reviewed with falls in a			shared with the Survey Team	
	sample of 14.				prior to the survey completion. Star Program indicating	-
	_				resident not to be left unattend	led
	Findings include:	:			in the restroom added to the ca	
					plans of those resident's who	
	1. Resident #42's	s record was reviewed on			were added to the program. T	
		p.m. Resident #42's			program is ongoing. Added to new employee orientation A	
	· ·	ed, but were not limited			Prevention In-service, in which	l l
	_	behavior disturbances,			fall prevention interventions ar	l l
	•	ular degeneration.			various situations r/t cognition	
	anxiety, and mae	and degeneration.			were discussed, was conducted	l l
	A Significant MI	OS (Minimum Data Set)			for all employees and has bee completed Shared with the	n
	_	d 2/11/11, indicated			Surveyors prior to the complet	ion
	-	ognition status was			of the survey was: All facility s	
		d, required extensive			(during the survey) signed and	
	J 1	· •			acknowledged resident safety	NF.
		f for transfer, limited			and interventions if noted to se remove an alarm. this also ha	• • • • • • • • • • • • • • • • • • •
		staff for ambulation, and			been added to new employee	<u> </u>
	had prior falls.				orientation. Form #2 Review	of
		1 1 1 7/0 / / 1 0			all current resident Fall	.
		ment, dated 7/24/10,			Prevention Measures, Fall Ris Assessments, Personal Care	K
		of 17, placing the			Records and Care Plans will b	e
	resident at a high	risk for falls.			reviewed and updates complete	I
					by: 04/24/2011. Will continue	e to
	A Nurses' Note, o	dated 9/1/10 at 11:20			review @ least quarterly The	

l	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		624 E ²	ADDRESS, CITY, STATE, ZIP CODE 13TH ST MAC, IN46996	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
TAG	a.m., indicated "I on floor on stomaton bathroom door. It toilet s/ (without size bump to L (I (and) abrasion to C/O (complaint of area. Res noted go O/ (no) bleeding O/ external rotati (arrow down) (look A History and Ph dated 9/3/10, indicated 9/3/10, indicated the resist attempting to trainestroom. The Poindicated the CN During an intervipum, the DoN (I indicated a CNA unsupervised in the indicated the CN are at risk for fall residents unatten The DoN indicated the CN indicated the CN are indicated the CN are indicated the CN are indicated the CN indicated the CN are indicated the CN indicat	Found res (resident) lying ach in room next to Res transferring self from a assist. Noted golf ball eft) side of forehead et a L eyebrow et to L wrist. Of) pain to hip/pelvic guarding hip/pelvic area. For further injury noted. For or shortening of ower) extremities" In a side of forehead et a L eyebrow et to L wrist. Of) pain to hip/pelvic area. For further injury noted. For or shortening of ower) extremities" In a side of forehead et a L eyebrow et a L eye	IAG	Director on Nursing or designee to monitor falls and interventions/reductions daily in the stand up meeting, were in Risk Management and Queast quarterly.	d y ekily
				ļ	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155660		(X2) MULTIPLE CC A. BUILDING	NSTRUCTION	(X3) DATE COMP. 03/25/2	LETED	
	PROVIDER OR SUPPLIER		624 E 1	ADDRESS, CITY, STATE, ZIP COD 3TH ST IAC, IN46996		
	SUMMARY S (EACH DEFICIEN REGULATORY OR disciplined for le in the bathroom. A Nurses' Note, of indicated "CNA" lying on floor in in supine position yelling 'Oh my h down) (under) re reported 'on her y noted to have dry to side c/ (with) p down) (under) he Pressure applied of resident's head A Nurses' Note, of p.m., indicated " x (times) 4" A Fall Risk assessindicated "staff unattended on to A care plan for a 6/24/10, lacked to	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) raving the resident alone dated 3/8/11 at 7:30 p.m., reported resident found her room. Resident lying n on the floor. Resident ead' blood noted (arrow esident's head. Resident way to bed.' Resident y heaves et gently rolled pillow placed (arrow ead for alignment. c/ cold compress to back d" dated 3/8/11 at 10:00 Resident received staples	STREET A 624 E 1	3TH ST	CTION JLD BE	(X5) COMPLETION DATE
	as current on 3/23/1	Sheet, received from the DoN 1 at 1:38 p.m., lacked of leaving the resident the bathroom.				

STATEMEN	T OF DEFICIENCIES	CIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155660	B. WING		03/25/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8	l l			
PULASKI HEALTH CARE CENTER		ENTED		I3TH ST		
PULASK	I HEALTH CARE CE	ENIER	WINAW	IAC, IN46996		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	During an interview	on 3/23/11 at 1:10 p.m., the				
	DoN indicated the C	CNA was suspended for leaving				
	the resident unattend	ded on the toilet. The DoN				
		nt should not have been left				
		The DoN indicated everybody				
		n September not to leave the				
	resident unattended	in the bathroom.				
			1	l		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING B. WING (33/25/201)		ETED			
	PROVIDER OR SUPPLIER			624 E 1	ADDRESS, CITY, STATE, ZIP CODE 3TH ST IAC, IN46996		
PULASK (X4) ID PREFIX TAG F0323 SS=G	SUMMARY S (EACH DEFICIEN REGULATORY OR 2. Resident # reviewed on p.m. Reside included, but to, demential depression. An annual M with an assed date of 1/25 resident was with cognition assistance of for transfers toilet use. The fallen since for the resident was and had min the resident assessments indicated a total the form incomplete the resident assessments indicated a total the form incomplete the resident assessments indicated a total the resident assessments indicated a total the form incomplete the resident assessments indicated a total the resident assessments.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) #13's record was 3/21/11 at 12:35 ent #13's diagnoses t were not limited , arthritis, and #IDS assessment, ssment reference //11, indicated the severely impaired on, required limited f one staff member , ambulation, and the resident had the last assessment or injuries.	F032	WINAM ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEPICIENCY) F 323 - Free of Accident Hazards/Supervision/Device-Prior to the survey all staff sign acknowledgement of terminati if found to have left a resident with fall risk and poor safety awareness unattended. This vadded to new employee orientation During the survey Star Program was put into plan Nursing Form #1. This was shared with the Survey Team prior to the survey completion. Star Program indicating resident not to be left unattend in the restroom added to the coplans of those resident's who were added to the program. The program is ongoing. Added to new employee orientation A Prevention In-service, in which fall prevention interventions are various situations r/t cognition were discussed, was conducted for all employees and has been completed Shared with the Surveyors prior to the complete of the survey was: All facility is (during the survey) signed and acknowledged resident safety and interventions if noted to see remove an alarm. This also has been added to new employee orientation. Form #2 Review all current resident Fall Prevention Measures, Fall Ris Assessments, Personal Care Records and Care Plans will be reviewed and updates comple by: 04/24/2011. Will continued	ned on was a ce	(X5) COMPLETION DATE 04/24/2011
					review @ least quarterly The		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	(X2) MULTIPLE CONSTRUCTION			X3) DATE COMPI	
MOTLAN	or condition	155660		A. BUILDING B. WING			03/25/2	
			B. WI		ADDRESS, CITY, STATE, ZIP CODE	_		
NAME OF F	PROVIDER OR SUPPLIER	t .		624 E 13TH ST				
	I HEALTH CARE CE				AC, IN46996			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUI	D BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE		DATE
	A care plan,	dated 6/24/10,			Director on Nursing or designee to monitor falls	and		
	indicated "R	esident is at risk			interventions/reductions of	laily		
	for falls r/t (related to)			in the stand up meeting, value in Risk Management and			
	dementia1	/13/11 Resident			least quarterly.			
		ame out from under						
	her' Res (res	ident) confused at						
		uraged to call for						
	assist prn (as	s needed). Alarms						
	added at this	s time1/14/11						
	Resident ren	noving personal						
	alarm and ge	etting up w/out						
	(without) ass	sist. Educated						
	resident on r	risk and she						
	acknowledge	ed, still removes						
	alarms r/t co	gnitive level"						
	The CNA as	signment sheet,						
	received from	m the DoN on						
	3/23/11 as cu	urrent, lacked						
	documentati	on to indicate the						
	resident was	at risk for falls or						
	of any alarm	s used by the						
	resident.	-						
	The nurses' i	notes, dated						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	PVJH11	Facility I	ID: 000553 If continu	ation she	eet Pa	ge 20 of 23

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 155660		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		624 E	ADDRESS, CITY, STATE, ZIP CODE 13TH ST MAC, IN46996			
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	BE	(X5) COMPLETION	
TAG		230 a.m., "Called	TAG	DETERMET)		DATE	
		n. Res sitting on					
		she fellSwollen					
	area 9 cm (c	entimeters) x 8 cm					
	x 2.5 cm c (v	with) purple					
	discoloration	n to rt (right) outer					
	forehead/rt o	outer eyebrow area.					
	Just below a	swollen area					
	measuring 3 cm x 2 cm x 0.2						
	cm skin colo	ored. Reports some					
	rt hip discon	nfort c walking"					
	1/25/11 at 4: "Writer ob down the ha	ervice notes, dated 00 p.m., indicated served res walking Il later and she had hand instead of					
	"Res yelled on her button her room. Sh	notes, dated p.m., indicated l'Help!' Res found ck on the floor of ne stated 'My feet n underneath me.'					
				ļ			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLI	
		155660	B. WIN			03/25/20	011
NAME OF I	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE 3TH ST		
PULASK	I HEALTH CARE CI	ENTER		1	AC, IN46996		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Personal ala	rm did not alarm					
	due to res re	moving alarm					
	frequently	"					
	During an in	nterview on 3/22/11					
	at 4:45 p.m.,						
	(Assistant D	pirector of Nurses)					
	indicated she	e was aware the					
	resident had	been taking off her					
		re the fall on					
		e indicated with the					
		gnition level they					
	l	te but it did not do					
	' '	he indicated if the					
	resident was	going to get up					
	she was goir	ng to get up. She					
	indicated aft	ter the second fall					
	they change	d the resident to a					
	pressure alai						
	r-czz me one	•					
	 During an ir	nterview on 3/23/11					
		, the DoN indicated					
	1	signment sheets					
		•					
	were not bei	ng updated.					

OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155660	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMF - 03/25/	LETED
PROVIDER OR SUPPLIEI		STREET A 624 E 1	ADDRESS, CITY, STATE, ZIP COI 13TH ST 1AC, IN46996	DE	
I HEALTH CARE C SUMMARY S (EACH DEFICIEN		STREET A 624 E 1	13TH ST	ECTION ULD BE	(X5) COMPLETION DATE